Montana Fetal, Infant and Child Mortality Review

First Report **November 2002**

Executive Summary

Montana's Fetal, Infant and Child Mortality Review program is a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on lessons learned from the reviews of the deaths. This process was authorized in statute (MCA 50-19-401 through 50-19-406) in 1997.

Montana's inaugural report includes a mix of data on all Montana fetal, infant and child deaths and the findings from the community level reviews. There were a total of 865 fetal, infant, and child deaths from 1997 through 2000. Four hundred twenty-seven (427) of these deaths were reviewed by the local review teams.

The reviewed deaths are not a scientific sample of all fetal, infant and child deaths in Montana. The reader should be cautious in extrapolating findings based on the death reviews in this report to all of the deaths occurring in the fetal, infant and child population of Montana.

Findings

- **Preventability**—140 (42%) of the 401 reviewed deaths with prevention findings were determined to be preventable.
- **Disparity**--Per 2000 U.S. Census, there were 230,062 infants and children under the age of 18 in Montana.
    - About 10% of that population is Native American, 85% is white, and all other races are 5%.
    - 16.8% of the fetal, infant and child deaths are Native American. A disproportionate number of Native American children in Montana are dying.
- **Primary Causes of Infant Death: (**163 infant deaths reviewed.)
    - Congenital anomalies, prematurity, and Sudden Infant Death Syndrome.
- **Primary Causes Child (Ages 1 – 17) Death: (**142 deaths reviewed.)
    - Unintentional injuries (50%), natural causes (29%) and suicide (12%).
- **SIDS**: 63% of Montana SIDS deaths were reviewed.
    - 68% of babies were found in the prone (tummy) position.
    - Prenatal smoking was found to be the second leading risk factor.
- **Unintentional Injuries**: the leading cause of death of children from 1 to 21 yrs.
    - 43% of the unintentional injury deaths of children ages 17 and younger were reviewed; 95% were determined to be preventable.
    - 56% of unintentional injury deaths were due to motor vehicle crashes.

- **Drowning**: 47% of the drowning deaths were reviewed. 7 of the 10 children who drowned were not adequately supervised.
- **MVC (motor vehicle crash)**: 94% of reviewed MVC deaths were preventable
    - 65% of all MVC deaths were male
    - 20% (twenty six of 130 deaths) of all MVC deaths were Native American. Montana motor vehicle death rate for Native Americans was 2.27 times the rate for white children.
    - One third of the drivers at fault were eighteen years or younger. Driver error, including speeding and recklessness, were reported in 87.5% of those cases.
- **Homicide**: there were 19 child homicides in Montana in this four-year period.
    - Ten of the 19 were committed with a firearm.
- **Child Abuse and Neglect:** of the 427 deaths reviewed, abuse was substantiated for 11 deaths, and alleged for another eight.
    - 8 of the 11 substantiated abuse cases were Native American.
- **Suicide:** there were 38 suicides in the four-year period.
    - 29 were white males; five were Native American males.
    - 17 of these suicides were reviewed.
    - A firearm was used in 13 of the suicides, all by males.
- **Firearms:** 12 children die as a result of firearm incidents every year; there were:
    - 48 firearm deaths in the four-year period.
    - 26 of these firearm deaths were suicides; 10 were homicides.
    - 22 had fatality reviews completed; a handgun was used in 7 of the suicides; a rifle was used for another five.

Preventability Actions Implemented (partial listing)

- Requested every hospital in Montana to examine their infant sleep position policy and model the "Back To Sleep" message in their nurseries.
- Achieved an Administrative Rule Change, which requires CPR training for all licensed day care providers.
- Aired Public Safety Announcements on water safety.
- Supported graduated licensing legislation.
- Produced and aired a PSA on gun safety.
- Initiated "Yellow Ribbon" campaigns for suicide prevention.

Statewide Prevention Recommendations (partial listing)

- Require that a SIDS diagnosis meet the criteria of autopsy, scene investigation and review of medical history.
- Distribute handgun safety information during well-child checks.
- Install self-locking gates on backyard pool fences.
- Providers should screen adolescents for risk of suicide at all routine exams and ask if a firearm is present in the home.

To obtain further information, contact:
Wilda McGraw, RN
Fetal, Infant and Child Mortality Review Program
Montana Department of Public Health and Human Services
Cogswell Building, 1400 Broadway
Helena, MT 59620
Phone: (406) 444-3394 Fax: (406) 444-2606
E-mail: wmcgraw@state.mt.